OUTPATIENT SERVICES EAST
ALLERGIES AND HOME MEDICATION LIST (AS PROVIDED BY THE PATIENT)

Patient Name:_____ **Date:**_____

Medication Allergies	Type of Reaction or Sensitivity	Medication Allergies	Type of Reaction or Sensitivity

Medications include prescriptions, over the counter, herbals, creams, vitamins, birth control products, etc.

Name of Medication(s) Currently Taking	Amount taken *(dosage)*	Last taken *(date/time)* ***Nurse only***	Name of Medication(s) Currently Taking	Amount taken *(dosage)*	Last taken *(date/time)* ***Nurse only***
			Are you on home oxygen therapy: [ ] YES [ ] NO		

Prescriptions Given at Discharge ***(Complete only if change made to routine medication list)*** ***NURSE(S) USE ONLY***

Drug	**Dosage**	**Frequency**	**Refills**
_____#_____	_____	_____	_____
_____#_____	_____	_____	_____

Resume all home medications as directed by the prescribing physician(s) with the exception of:

☐ Form updated and copy given to patient _____
Initials

place patient label here